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ABSTRACT

This newsletter theme issue addresses the needs of infants and young children at risk due to economic, cultural, and environmental disadvantages. Individual articles have the following titles and authors: "Understanding the Early Experience of Black Children in High Risk Environments: Culturally and Ecologically Relevant Research as a Guide to Support for Families" (Dolores G. Norton); "Infant-Parent Intervention with Recent Immigrants: Reflections on a Study with Latino Families" (Alicia F. Lieberman); "Serving the Newest Arrivals: A Model of Early Intervention for Central American Babies and Their Families" (Maria Elena Orrego and Ann B. Barnett); "Ethnic Differences in the Transition to Parenthood" (Lorraine F. Kubicek et al.); "The National Center Fellowship Program: Nurturing New Leaders" (Carol P. Berman and Raymond C. Collins). (DB)

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[Supporting Culturally Diverse Families with Infants and Toddlers]

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Understanding the Early Experience of Black Children in High Risk Environments: Culturally and Ecologically Relevant Research as a Guide to Support for Families¹

by

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Picture a young black mother with a baby in her arms struggling against a strong wind to pull a cumbersome laundry cart three blocks from her housing project apartment to the nearest laundromat. Note the toddler at her side, clinging desperately to the cart, screaming in open-mouthed protest against the demands placed on his two-year-old capacities by his mother and the wind. Imagine the gray, cold, garbage-strewn street, the junk automobiles, the looming, empty, cavernous buildings, and the burdened mother's sense of helplessness.

What is this child experiencing? What clues is he receiving about his mother's ability to control and protect him, and about his own sense of self?

Isolated in inner cities behind barriers of concrete, barred windows, railroad trestles and superhighway curves are many infants and toddlers whom most Americans never see. More and more black children are born into such high risk environments. More than 55 percent of all black children born in the United States today are born to single, primarily adolescent, lower

SES mothers (Edelman, 1987). Black children in America are losing ground; they are more likely to be born into poverty today than five years ago. They experience higher rates of infant mortality and illness, are often



STEVE BARRETT

¹Based upon a paper presented at NCCIP's Sixth Biennial National Training Institute, Washington, D.C., December 1989.

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scarred emotionally and socially by family and community turbulence and violence, and face disproportionate early school failure compared to other American children. These are children whose potential will be lost if we fail to develop effective interventions for them and their families.

Knowledge is the first step toward meaningful support for children in high risk environments. We need a more precise description of what children learn from life in the inner city in the 1990s. Since some children from high risk environments do succeed, we need to know not only what winds buffet them but also what forces support them in their natural environment. Only then can we develop "culturally and ecologically" sensitive interventions (Garbarino, 1990; Lieberman, 1987). We need to understand the tapestry of the early natural experiences of children, the forces that shape their world view and their reality, if we are to develop relevant, acceptable and effective services.

"Child rearing practices reflect what parents know about life in their community, what they believe will be useful, and what they recognize as realistic aspirations for their children."

This paper presents a nonjudgmental approach to understanding cultural and ecological differences in socialization and the use of the approach in the Infant Development Project: Children at Risk (IDP). The paper examines the development of a sense of time as one subtle dimension of differential early socialization which may have implications for children's capacities to function in the world external to their family. Finally, the paper explores the implications of our preliminary findings for intervention with mothers and children in the inner city.

An anthropological framework

Much child development research in the 1970s documented the connections between child rearing patterns in varying racial and socioeconomic groups and differing child development outcomes. These studies directed our attention toward differences in patterns of parent-child, social, emotional and linguistic interaction. When differences are emphasized, distinctions tend to become pejorative—one approach to child rearing becomes seen as better, another as worse; one pattern of development is designated as "normal," and anything different becomes "abnormal." Few studies from this era looked for common or universal human needs that might underlie observed differences.

The anthropological approach described here seeks instead to discover universal guides to societal organization, as people are observed developing preferred ways of relating to others, meeting needs, and developing schemata for conceiving of self and others. The content and meaning of such guides depend on the location of the family in a particular group, time

and place. Thus, content and meaning will be different depending upon the total historical, cultural, and ecological context within which the family finds itself.

All human societies have some guides or control mechanisms (Geertz, 1973) that direct relations

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between children and adults. Most societies entrust their newborns to some form of the family to socialize them—to prepare them for competent adulthood within their own social group. Human beings raise their children to fit into the society they know. Child rearing practices reflect what parents know about life in their community, what they believe will be useful, and what they recognize as realistic aspirations for their children.

This anthropological framework is relatively easy to adopt when comparing differences between societies that are themselves homogeneous. It is more difficult to apply in a diverse, changing society such as the United States, which is composed of many subgroups with different heritages, different economic and social histories, and differential access to the major institutions and resources of the society. If families are isolated in the inner city, separated from major societal institutions and resources, they may not be able to teach their children the "rules and tools" for success in the larger society. Families raise their children to fit into the society in which they live and which they know. They cannot give meaning to values they do not share, nor provide experiences which do not exist in their environment.

The Infant Development Project: Children At Risk (IDP)²

The Infant Development Project: Children At Risk (IDP) is a research effort based on the recognition that many of the children who live behind the concrete and socioeconomic structural barriers of the inner city may be socialized in ways not wholly captured in the academic and professional literature. Guided by an anthropological framework and influenced by Bronfenbrenner's (1979) ecological systems model, the IDP project is attempting to document and understand the early developmental experiences of a small sample of inner-city, low-income black children of adolescent mothers. We are using a longitudinal, modified ethnographic approach, which studies behavior from the meaning and perspective of the persons being studied. In order to describe more precisely the patterns of interaction that occur in the natural early environment of the children, we videotape the target children for four hours at a time, in their homes or wherever they go during the taping period. The project is endeavoring to understand what observed patterns of interaction mean to the families and how they relate to developmental outcomes. The ultimate goal is to use such information to develop family support interventions and school curriculum for the children based upon what is acceptable, possible and effective in their community.

The original study from which this paper was developed follows a group of children from birth through first grade. The sample was deliberately stratified to study children whose social and physical environment put them at highest risk in all areas of development: physical, social, emotional and cognitive. The sample consists of all mothers who gave birth at

Editors' note:

The articles in this issue of *Zero to Three*, as well as many of the books and reports noted in the Publications section, describe the complexity of finding culturally sensitive and appropriate ways to support families with infants and toddlers in a diverse, rapidly changing society.

The practitioner's first challenge is to understand the perspective of individual families and of groups of families. How did the parents of today's parents manage childbearing and child rearing? What supports that existed in the past are available today? What demands and what opportunities are new, for parents, grandparents, and children? Is change experienced as hope for new possibilities, as challenge, as loss? Is a family part of a community that has expectations for children and parents, but that also offers support? If not, do families see ways to enrich their circumstances—or to escape them?

The practitioner's second challenge is to help culturally diverse families improve their lives and those of their children in ways that are meaningful to them. Policymakers, program designers and practitioners need not, as the articles in this issue illustrate, abandon their own clearly-stated goals—for example, to improve the quality of parent-child relationships, to ensure early and regular prenatal and pediatric care, to give children and parents the "rules and tools" for achievement in the mainstream culture. Yet for service programs to achieve their goals, practitioners must be able to respect and respond to families' experiences—to meet parents and children where they are, to listen to stories of their journey, and to accompany them on their way.

two major metropolitan hospitals during the three months of sample collection who met the following criteria:

- They did not live with their mothers or older relatives (young mothers living alone are more at risk than those living with supportive extended family members);
- They were between 18 and 22 years of age and had had their first baby when they were teenagers;
- They were not going to school full time (the mean educational level was 11.5 years);

²This project was supported by grants from the Spencer Foundation, Childhelp, Inc., the Schnadig Foundation, the University of Chicago Women's Board and the Washington National Insurance Company. The author wishes to thank Karen Freil, Lorraine Kubick and Jacqueline U Dren for their videotaping and participation in many other phases of the project; Anne Stalley who coordinated much of the project and worked on developing the codes, transcriptions, coding and other analysis with Sherrill Sellers and Kathy Doyle and Sheri Dingsus; Joan Palmer who approached the mothers in the hospital; and the mothers and children without whom the research would not have been possible.

- They lived in census tracts which were below the city median on per capita income and housing value, but with higher than average rates of crime, transience and neonatal mortality.

Although 38 mothers meeting the criteria agreed to participate in the study, one baby died of SIDS at 10 weeks. Approximately 26 mothers of the original 37 (70%) remain in the sample after six years of study. We collected data by videotaping mother and child in the hospital the second day after birth, videotaping in the home every six weeks during the child's first year, and thereafter videotaping in the home at regular intervals of not longer than six months. In addition to the videotapes, we have life histories on the mothers including medical and work histories, as well as data on social and cognitive functioning of both the mothers (Wechsler Adult Intelligence Scale) and the children (the McCarthy Scales of Children's abilities at ages 3 and 6). From diaries of the researchers recording off-camera activities and from our frequent visits we have learned about families' friends, housing problems, education, extended family, drug use and other illegal activities, and even happy times. This process has given the project an extraordinary window into the children's daily lives.

"The development of a sense of time is one example of how subtle differences in early socialization may have a profound impact on children's abilities to adapt and achieve in the larger society."

The IDP Project is examining many facets of parent-child interaction, language, and communication within the child's environment. The project is particularly interested in differences in socialization that occur within our demographically homogeneous study population. The development of a sense of time among the children in our study is one example of how subtle differences in early socialization may have a profound impact on children's abilities to adapt and achieve in the larger society.

Early development of a sense of time

Our interest in the development of a sense of time (temporal development) among the children we were studying grew out of the findings of two earlier studies that some children from lower SES black families probably do not encounter a structured time environment until they enter preschool or kindergarten (Farran, 1982b; Brice-Heath, 1984). Brice-Heath's ethnographic study of lower and higher SES black children and white children found that the typical preschool structure based upon a "time for clay, a time to draw, a time to nap" (p.275), with little attention to the completion of a task, caused great frustration for the black lower SES youngsters whose early home lives seemed to have no structure related to time. Arriving at school, these children did not appear to know how to govern their behavior in relation to the time

structure of the classroom. Similar insights come from the work of Ben-Baruch (1985) and Ben-Baruch, Bruno and Horn (1987), who have explored differences and similarities between the conceptions and attitudes about time that children bring to school and the conceptions and attitudes about time of their teachers.

What is a sense of time? Most Americans automatically and unconsciously orient their lives by their calendars and watches. It is almost impossible for them to step aside and contemplate time consciously. Awareness of time is linked to awareness of change. Humans see continuous change around them in the progression of the seasons, the growth of children, and the fading of night to day. They mark the sequence of these changes in memory and use them to make predictions about the future; they use these predictions to order their behavior. Thus humans develop a temporal framework in which to act, think and relate to the world based upon their understanding of the succession of events. This understanding of time is beyond clocks and calendar time. It is concerned with how humans experience and perceive the sequence of time in relation to their own actions. Understanding the sequence of time and the importance of ordering our behavior at one point in that sequence in relation to another helps us to attain desired goals, or to have some control over what will happen to us in the future. Children who know that if they sit down and color now, they will be able to go out and play later have this sense of time.

The sequencing of time through the past, present and future is called linear time. Understanding linear time permits us to erect a meaningful and coherent framework for living within a core self that relates consistently to our past and future, and helps us to maintain some control over the experiences in our environment. Connecting our experiences of the past to the present gives us knowledge of who we are and what goals we can aspire to in the future. (Michon, 1985).

Although there is no comprehensive theory about how children develop a sense of time, child development researchers, including Piaget, believe that the process begins very early in the interaction between babies and their families in the course of normal caretaking routines. Psychologist Kenneth Kaye illustrated the process in his studies (1977) of nursing and vocalizing patterns between mothers and babies. He found that when babies launch into a burst of nursing, mothers are usually quiet. When the babies pause, mothers talk to and stroke their infants. They become quiet again when the babies resume nursing. The same patterns occur with turn-taking in preverbal vocalization between mothers and infants. Many researchers suspect that this sensitive, responsive, reciprocal behavior of growing synchrony between the caregiver and the baby, so well described by Brazelton and his colleagues (1975), Tronick (1986) and many others, fosters infants' awareness of change and builds the foundation for understanding time. By the age of four months, children respond to caregivers with definite



rhythms of their own, making their personal contribution to transactions.

Language also plays a major role in the development of notions about the past, present and future. Individuals can share the present without language. But because they have no visible, external reality that can be shared (Harner, 1982), past and future can only be shared through verbal language or some recorded communication. Thus parents begin to share the "nonpresent" with the child through early conversation, particularly in their statements about time.

Not only is language about time vital to a child's growing understanding of temporal order, but the type of time language used is also important. Historically, investigators have divided time into "physical time" and "social time" (Friedman, 1982; Kant, 1951; Newtown, 1971; McGrath and Kelly, 1986). Physical time is the more quantitative, objective, mathematical concept of time, exemplified in absolute, collective units such as clock time, weeks, years, morning, and yesterday. We are talking about physical time when we say, "We will eat at two o'clock" or "He went home yesterday." Social time connotes a more qualitative, subjective view of time related to a particular social situation or event. "We will go after Granny comes home" or "Sit still until I finish" are statements about social time. In modern, technical societies physical time plays a dominant role in people's lives, including the lives of young children in school.

Some preliminary findings from the IDP Project

Studying our videotapes closely, and coding and

correlating time, parent-infant interactions, language, and behavior with developmental outcomes on seriation tasks measuring time development and other variables, we looked for systematic differences in early mother-child interaction and language that might be related to children's general social and cognitive development and to their temporal development. We found significant differences in how mothers' socialization practices conveyed a sense of time to their children.

First, we found that children who heard more statements about time in the course of their family's daily activities tended to score higher on seriation tests measuring beginning time concepts. We found statistical significance in comparing the children's scores on seriation tests with the mothers' time statements to the children, such as "We will go home after we finish eating" or "Put on your socks first, then your shoes." The children of the mothers who made such statements and who used words like "before" and "after" more often tended to score higher both on general cognitive indices and on seriation tests than the children whose mothers made fewer time statements.

Second, we found that the type of time language spoken by mothers is important to children's development of a sense of time. Most of the time statements that mothers made were social time, rather than physical time statements. However, the children who scored highest on time development heard far more physical time statements from their mothers (39 percent of all time statements) than lower scoring children (5 percent). Since physical time is the primary time language used in a modern society like the United States, and is the time language of school, children with early exposure and socialization to physical time may be better prepared for school than children who hear primarily social time statements.

"Mothers of children who developed a sense of time early on were themselves oriented toward the future and seemed to feel more in control of their lives than other mothers."

The children who tested well on our time measurements also had mothers who seemed to have a better sense of self-efficacy and control than other mothers in the cohort. These mothers were more future-oriented: they voiced plans, challenged personnel in renting offices, and refused to let the public assistance office change their family health services to a new HMO system until they found out about the services to be offered. From the videotapes, these mothers also appear to be establishing early synchrony with their infants.

Other young mothers in the study sample did not seem to mention time at all to their children, nor did the systematic four-hour videotaping sessions, alternately scheduled for mornings and afternoons, reveal much routine in their lives. These were homes where parents did not refer to clocks or calendars, but knew

their children should leave for school when a certain television show was on. The lack of structure meant not only that children missed out on educational and social opportunities, but also on much-needed health care. Not surprisingly, the children of these mothers tested lower on seriation measures.

Meanings

Our study looked to the daily environment of early socialization for clues about what mothers deemed important in their lives and why. The videotapes and life histories are beginning to tell us why time lacks importance in the lives of some of the young mothers in our sample, and thus does not appear in the early socialization of their children. Many of the inner-city mothers are too needy and too anxious to note and respond to their children sensitively enough to provide the reciprocal patterns of alternating synchrony mentioned earlier as necessary foundations for early time concepts. The videotapes reveal households so crowded with adults and other children that our target babies wander around in a welter of adults, almost like little non-persons, spoken to, curtly, only if they get in the way—especially if they wander between adults and an operating television set.

"In some of the households we visited, babies wander around in a welter of adults and other children, spoken to, curtly, only if they get in the way."

In some households, unemployed mothers have little reason to observe time. They do not talk to their children about clock time, social time, the past, or the present. Least of all do they talk about the future. In contrast, one working mother in the sample tells her child as she is preparing to leave the house, "Eat, if you want to get to Granny's in time to see Thunder-Cats." The statement cues the child to order her behavior in the present to bring about a desired activity in the near future. The child translates the statement, "Get rid of these eggs, so I can go to Granny's and watch TV."

This ability to translate time language to behavior is very important to children when they enter the time-slotted world of formal schooling. As Brice-Heath pointed out, the world of school was not created to match or adapt to the early socialization of a sub-group of inner-city children. We suspect that those children in our sample who have not been socialized to the time dimension will not be able to translate time language from the teacher to their own behavior.

Imagine yourself as a child in a classroom with adults who speak your language but whose directions you are unable to interpret, even though you may wish to please them. When you get up to see the gerbils, you are told to sit down, finish your coloring and wait to see the gerbils during free time. When you sit down to color, your paper is taken away before you finish, because it's ten o'clock and time for juice. Before you finish



SUBJECTS & PREDICATES

juice, it's "potty time." It's difficult to put the logic of this together if you are just four years old and you have not encountered such distinctions before in the home. You do not know how to govern your behavior by time. You have been robbed of the sense of efficacy and control so necessary to sequence behavior through time, to develop a sense of self, and to continue to learn. Brice-Heath found that when forced to fit their activities into specific time slots, the children in her study displayed behavior ranging from bewildered confusion to hyperactive resistance. Puzzled by such behavior and unaware of the daily patterns of children's home lives, teachers can underestimate the abilities of these children and make negative predictions about their potential.

Implications for intervention

In keeping with the need to "ground" research and theoretical findings and insights in work with special populations, the IDP project attempts to test whether its findings fit with the reality and world view of those being studied. To do this, findings can be presented to the young women themselves and/or to those working with such young families. When these findings were presented to the program supervisor and the family workers of a family intervention program in a large housing project, the family workers agreed that one of their concerns was the lack of structure in the lives of some of the young women with whom they worked. They also expressed concern that children were penalized by lack of structure in their families.

The family workers, who came from the community themselves, stressed that any intervention around time and structure would have to embody goals set by the mothers themselves. They suggested listening to mothers' own complaints about the difficulties of getting something they wanted for their children. A worker could pick up on such a complaint by saying, "Let's walk through what happened, what you did, to see if we can find a way to do it that will get what you want." In this "walking through," the worker uses the words "before" and "after" a great deal, speaking in a time language quite similar to that used by the more successful mothers on our tapes as they talk to their children.

The family workers also insisted that tangible incentives like disposable diapers, small amounts of money, or gifts that the mothers could select themselves be available to encourage mothers to follow through on each step of an intervention program. The supervisor's rationale for such a strategy reminded us of our anthropological framework. She noted that the mothers in our study see themselves as good mothers, giving their children what is needed in the world as they know it. They do not perceive most parenting or child development programs as something they want or need for themselves or their children.

Even mothers who are dissatisfied with their lives do not believe that they have the power to change their lives through their own efforts. Tangible incentives serve to motivate mothers to participate in a program. There is a time relationship built in when efforts in the present receive a reward in the future. Through relationships in the program, mothers are helped to explore their own past efforts to obtain some goal, and to evaluate and revise their present efforts. They experience some control and self efficacy; they begin to relate their actions through the sequence of time.

Efforts to intervene on behalf of others must be based upon knowledge of their world, not our own. We must strive for awareness of the nuances of difference, while also listening sensitively for the expression of common human needs.

Toward a coherent personal history

A three-year-old shows us how the awareness of time and of a core self may be connected through the development of a coherent personal history (Michon, Pouthas and Jackson, 1988).

Shown a house where her parents once lived, little Erin asked if she had lived there too. Told she wasn't born then, she asked if she was in her mother's tummy. Her mother replied, "Not yet; you were just a gleam in my eye."

A few days later, Erin was told about something else that had happened before she was born. She thought for a moment and then asked, "Was I in your tummy ... or was I in your eye?" Erin was already developing a concept of self based upon time, a concept that sequenced back through the relatively recent past of the tummy to the more distant past of "the gleam in

the eye." She was connecting it all to her present concept of an enduring self.

It is the wish for this kind of development for all children that keeps us seeking to make both research and intervention more culturally relevant.

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Infant-Parent Intervention with Recent Immigrants: Reflections on a Study with Latino Families

by

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The recent wave of immigration from Spanish-speaking countries is changing the demographic face of the United States. Expected to become the largest minority by the year 2000, the Latino community is facing the traditional challenges of disempowerment stemming from discrimination and lack of acculturation. Poverty, unemployment and low levels of education are over-represented relative to the general population. The psychological costs of these conditions are high as reflected in the prevalence of anxiety and depression. (Padilla, Carlos & Keefe, 1976).

"When parents are scared, depressed, and obliged to devote a large portion of their already strained psychological resources to securing the family's economic survival, it is difficult for them to be attuned to their children's needs."

This situation has serious implications for the mental health of Latino infants. When parents are scared, depressed, and obliged to devote a large portion of their already strained psychological resources to securing the family's-economic survival, it is more difficult for them to be emotionally attuned to their children's needs. They are less likely to have access in themselves to the parental availability, patience, playfulness, and ready delight that enable infants to thrive. There is some empirical support for this inference. In a recent study¹ with recent Latino immigrants, we found that 64% of the infants were classified as anxiously attached when assessed in the strange situation (Ainsworth et al., 1978). In contrast, only 35% of infants in non-clinical Anglo-american samples tend to be classified as anxiously attached. This classification does not by itself suggest a clinical condition, but it is certainly an early indicator of mental health risk.

The goal of our study was to provide infant-mother intervention to anxiously attached dyads in order to improve the quality of their relationship. There is much research evidence that anxious attachment in the first year of life is related to lower competence in later developmental tasks. For example, anxiously attached infants were less compliant with their mothers and less enthusiastic about solving a task than securely attached infants when observed at age 2; as preschoolers, they were less competent in peer relations and had lower

ratings in teachers' evaluations; by six years of age, they had a higher incidence of behavioral problems. (Matas, Arend & Sroufe, 1978; Erickson, Sroufe & Egeland, 1985; Lewis, Feiring, McGoffog & Jaskir, 1984).

We hoped that our intervention would help to prevent those later difficulties in our sample of anxiously attached Latino infants and their mothers. We believed that the second year of life would be a timely period for intervention because of the developmental challenges brought about by the transition from infancy to toddlerhood. These challenges include the consolidation of autonomous exploration, the expansion of language, and the increased self-assertion signalled by that classic developmental achievement, the mastery of the word "no."

The mothers were recruited from well-baby clinics because we were seeking a non-clinical population whose difficulties could be understood in terms of situational stress rather than deeply rooted psychopathology.

The intervention started when the infants were 12 months old and it ended shortly after their second birthday. Each mother was assigned to one intervenor,² who was a bicultural woman with a master's degree in psychology or social work and with experience working in the Spanish-speaking community. The format was a weekly session lasting 1½ hours and conducted either at home or in our playroom, as preferred by the mother. Both the baby and the mother were present in these sessions. Fathers were not formally involved in the study because our focus was on quality of infant-mother attachment and because in the Latino culture mothers are clearly in charge of raising young children (Acosta, Yamamoto & Evans, 1982). However, the fathers were free to attend the session if they wished to do so and if the mothers agreed. Most fathers welcomed the intervention and some did participate occasionally, but the general paternal consensus seemed to be that what the mother and the intervenor were doing was "woman's business."

The intervention model

The intervention model involved a flexible integration of different therapeutic modalities—specifically, concrete assistance, emotional support, developmental guidance and infant-parent psychotherapy. This approach was initially developed by Selma Fraiberg (1980) and we continue to apply it, expand it and refine it at the Infant-Parent Program (Lieberman and Pawl, 1988). The emphasis is on understanding the subjective experience of the parent and the baby as a prerequisite for intervention. There is no didactic teaching in an effort to change maternal or infant behavior. We believe that behavior is the external manifestation of internal experience, and behavioral changes are expected to ensue from changes in the mother's and infant's

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²There were four intervenors: Cristina Casero, Ruti Gubkin, Marta Martinez and Maria Alvarez.



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experience of themselves, of each other, and of their relationship. In this model, information about infant development is introduced with an awareness of clinical considerations and in ways that are geared to the mother's and infant's temperament and individual style.

Our intervention was successful in improving the quality of the relationship and the social-emotional functioning of both mother and child. Outcome measures show that when compared to a control group, the mothers receiving intervention became more empathic and more playfully interactive with their children. Toddlers in the intervention groups showed less avoidance, resistance and anger towards their mothers than toddlers in the control group. Mothers and toddlers in the intervention group were also better able to negotiate with each other the strains of a brief (10-minute) separation and subsequent reunion.

Culturally relevant considerations

The effectiveness of the intervention has given us a secure base for some reflections on the parameters of success in working with our sample.

When we first designed the study (and before we were funded), we spent considerable time thinking about the "natural support systems" (Valle and Vega, 1980) occurring in the Latino community. We wanted our intervention to be sensitive to the particular needs of our sample, and as a result we endeavored to imbue our regular approach to intervention with a keen awareness of culturally relevant patterns, formats and values.

We were particularly impressed by two cultural roles of great centrality in the support network of Latina

women: the "comadre" and the "madrina" (Valle and Vega, 1980). Comadres are female peers who serve as confidantes and providers of mutual emotional and practical support. The madrina is a woman who is selected by the parents as the "co-mother" of their infant, who is willing to share in the responsibility of looking after the child's welfare, and to whom the mother may turn for guidance, support and advice in situations of doubt, confusion or stress.

Committed as we were to a culturally relevant approach to intervention, we decided to design a format that integrated the principles of infant mental health as practiced at the Infant-Parent Program with a clinical replication of the roles of the comadre and the madrina.

Our initial plan was to offer the mothers in the intervention group a weekly group meeting led in Spanish by a bicultural group coordinator. In such a setting, four mothers could meet on a regular basis to talk about their lives, observe their own and each other's children, exchange views, and experiences, and last but not least, share a meal together. The role of the group coordinator would be to facilitate the group process, address and clarify feelings, bring the children's signals to the mothers' awareness, discuss childrearing issues, provide developmental information, and serve as a bridge between the Latino culture and the mores of the United States in order to aid in the adjustment to the new culture.

This format was intended to serve several functions simultaneously. We hoped that mothers in the group would gradually develop into a peer support group, relieving their pervasive isolation and providing company and concrete assistance for each other. We

believed that for these mothers with few sources of emotional support, the friendships established in the group would gradually come to fulfill the role that their comadres had in their countries of origin. We also hoped that the group coordinator would serve a function somewhat similar to that of a *madrina*—knowledgeable, supportive, and available to discuss emotionally charged topics. We envisioned a kind of sisterhood where women developed with each other the traditional bonds of "confianza en confianza" (mutual trust) through the process of sharing acculturation, childrearing and personal issues with each other.

"We envisioned a sisterhood where women could develop traditional bonds of mutual trust through sharing acculturation, childrearing and personal issues with each other . . . The mothers decided otherwise."

It was not to be. The mothers decided otherwise, not explicitly but eloquently enough through the most powerful means of communication at their disposal: lack of attendance at the group meetings. All the mothers who were offered the group agreed to participate. However, instead of coming to our office at the time that the group was supposed to meet (a time they had helped to set up), they often came on different days or at a different time, openly seeking an opportunity to be alone with the group coordinator. When the group did meet, the mothers were more often than not critical of each other and of each others' children, family background and country of origin. They also openly vied with each other for the favor of the group coordinator. It became clear that each of these mothers, who felt deprived and alone, was looking not for the comadres we had tried to construct for her but for a mother figure whose attention could be bestowed on her alone.

The psychological reasons for this became clear soon after we abandoned the idea of a group and offered individual sessions instead. Within a month, attendance increased by 75%. As the history of each mother emerged in the course of these sessions, a picture of great hardship emerged. Many of the mothers came from very large families where there were few material and emotional resources to share. A substantial number of them were sent away to work as servants at an early age; others endured different forms of separation. Harsh physical punishment was commonplace, often to an extent that would be legally considered as abuse in this country. Family feuds, probably fueled by the socioeconomic stress, were frequent in their families of origin. It was not surprising in this context that there was such a high incidence of anxious attachment in the infants in this sample. The stresses experienced by these mothers did not begin with immigration but were deeply rooted in their childhood. We were witnessing a generational transmission of conflicted relationships. It also became clear that, although we had recruited

the mothers from non-clinical settings, there was a high incidence of clinically documentable depression in our sample.

The background of these women and the strong emotion they experienced as they told it taught us two major lessons. First, it let us appreciate how wise they had been in refusing a group format and insisting (non-verbally) on individual sessions. The difficulties these mothers needed to address within themselves and in their relationship with their children required a private setting where the full emotional impact of their experiences could be explored in the context of a trusting relationship with the intervenor. "Ghosts in the nursery" cannot be exorcised in public, and these mothers knew it.

The second lesson these mothers taught us is that indigenous cultural institutions are not easily imported. When a culture is disrupted by immigration and transplanted to another country, new traditions need to be fashioned that build on but cannot be identical with those that were left behind. We could not replicate the roles of the comadre and the *madrina* on foreign soil just because it seemed conceptually elegant and clinically and culturally useful to try to do so.

"We learned, first, that there is no substitute for a solid therapeutic relationship in the work of intervention and, second, that indigenous cultural institutions are not easily imported."

It is possible and even likely, of course, that the mothers in our sample could enjoy and benefit from participating in a group once their more urgent need for individualized attention was less salient. We did not have the opportunity to explore this possibility in our study. It is even possible that the intervenor came to acquire some of the characteristics of a *madrina* as the relationship deepened. Several mothers asked their intervenors to participate in religious ceremonies involving their child, just as a *madrina* would do. But these features emerged spontaneously from the strength of a therapeutic relationship, and were not preplanned in an effort to be culturally relevant.

Conclusion

We learned from this study that there is no substitute for a solid therapeutic relationship in the work of intervention. In retrospect, this was to be expected. Cultural sensitivity is, at its best, a specialized form of interpersonal sensitivity. Everything we do to understand a family's culture will improve the quality of our work: learning about its traditions, trying to understand the origin and the function of its values, appreciating the benefits and empathizing with the costs inherent in its world view.

However, it is possible, to paraphrase Winnicott, that ultimately there is no such thing as a culture: there are only human representatives that embody different

versions of an abstract and fluid cultural ideal. This is particularly the case where migration is involved. Recent immigrants are people in flux: they are no longer who they were in their homeland and they are not yet who they will become once they adapt to their new country. As intervenors, we need to respect the transitional nature of their experiences: the mixture of sorrow for the lost ways and hope for the new possibilities that George Pollock has aptly called the "mourning-liberation process." We also need to discover the uniquely individual nature of their relationship to their culture of origin and to their adopted land. If we can do all this, we will be truly responsive to cultural differences because we will be responding not to an abstract conception of a culture but to who each person really is.

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Call for manuscripts

A special issue of *Children's Health Care*, the Journal of the Association for the Care of Children's Health, will be entitled "Psychosocial Clinical Skills." The issue will focus on psychosocial interventions that enhance a child's and family's experience with health care, and on the efficacy of these interventions.

The deadline for submission of manuscripts is **August 1, 1990**. Guidelines can be obtained from Joy Goldberger and Belinda Ledbetter, Johns Hopkins Children's Center, Child Life Department, 600 North Wolfe Street, Ballock 174, Baltimore, MD 21205.

Serving the Newest Arrivals: A Model of Early Intervention for Central American Babies and Their Families

by
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The Family Place, a bilingual and bicultural family resource center in Washington, D.C. has served more than 2400 Central American immigrant and refugee families since it was established in 1981. The goal of Family Place is to promote the health and well-being of children birth to three. To serve women who are unaccustomed to seeking help in child rearing from an institution, and who often come to Family Place in crisis, the center works hard to humanize its services and, above all, to establish a trusting relationship with all participants.

Three-quarters of the women who come to Family Place are either pregnant or have a child less than a year old. (The largest number of referrals comes from former program participants.) More than half of Family Place parents came to the United States from Central America after 1982, and thus are ineligible for amnesty under the provisions of the Immigration Reform and Control Act of 1986. Almost 40 percent of participants have not gone to school beyond the eighth grade. Almost no one has extended family living in the area.

In addition to the problems of inadequate shelter, food, employment opportunities and medical care faced by many poor families in this country, the women and children who come to Family Place face stresses specifically related to the circumstances of their immigration.

- Experiences such as prolonged separation, exposure to the lifestyles of American men and women, and new roles in the job market have caused major shifts in male/female roles. While a better balance may emerge in time in the Hispanic community, it is currently the case that many immigrant women are alone during their pregnancy or have unsatisfactory relationships with their male partners.

- Their distance from family leaves Hispanic pregnant women and new mothers unsupported, afraid, and feeling extremely vulnerable. In their native countries, these women would typically obtain health information and assistance from a large and well-established support network rooted in the extended family. The extended family would also monitor fathers' behavior, supporting and expecting responsibility, and would provide children with a network of stable, loving relationships.

- New immigrants also lack the peer support and potential for information sharing that many young women find in the workplace. With limited job training and proficiency in English, and without legal permission to hold employment, Hispanic women are likely to work in isolation as domestics in private households.

• "Undocumented" status prevents many Central American parents from obtaining or keeping a job. Since their culture values hard work, unemployment not only has economic consequences for themselves, their children, and families left behind but also has a major destructive impact on their sense of identity and self worth.

• Undocumented status makes families ineligible for public supports such as food stamps, child welfare benefits, and Medicaid. Families are aware that "becoming a public charge" may adversely affect any future application for legal immigrant status. Ironically, this awareness keeps many families from seeking medical care that may be available through special city funding appropriations.

• The health and social services typically available to low-income families in the District of Columbia are fragmented, inflexible, discontinuous, and inaccessible. The difficulties of Hispanic parents are compounded by a lack of official translators (obstetricians and pediatricians may rely on clinic clerks or cleaning women to translate medical advice), as well as by both linguistic and cultural barriers to seeking clarification and explanation. There are few resources to address the mental health needs of men and women who have fled from first-hand experience of civil war and social chaos. Nor are the consequences of these experiences for the development of their young children well understood.

The Family Place works to guide parents from crisis to increased stability. The center has strived from its beginnings to humanize the delivery of services and activities that include social services and referrals; nutrition services; participant groups; prenatal and parent education and counseling; jobs skills development; advocacy; and the fostering of leadership and mutual support among program participants. Family Place is based on the premise that change for the better comes about in the context of good relationships, and that good relationships are established on a foundation of trust.

How Family Place builds trust, combats isolation, and fosters positive change is reflected in its initial approach to families, in its emphasis on both independence and interdependence, and in its extensive array of support groups, educational programming, and skill-building activities.

The first visit

Family Place uses all aspects of its program to convey a sense of comfort and the possibility of trust. Its physical layout is that of a large family home, with a comfortable living room, a spacious dining room, a kitchen, and a nursery. Participants can drop in any time that the center is open (Monday through Friday, 9 a.m. to 5 p.m.) and stay as long as they want. They are always welcomed.

Someone entering the center is likely to see three or more mothers in the living room, socializing and sharing in the tending of their babies and toddlers. The

first staff member to greet a new participant will be the center's receptionist, herself a former participant. Her presence and the fact that so many referrals to Family Place come from former participants increase significantly the level of comfort and trust among parents coming to the center for the first time.

Most people come to Family Place looking for one of three things: help with a major crisis, relief from physical and emotional stress, or limited/brief services. Only a minority of new participants include among their reasons for coming to Family Place the center's own major objectives: ensuring early and regular prenatal and pediatric care, and parenting education.

The bilingual intake worker who sees a new family ascertains the reason for referral as stated by the client (and referring agency where applicable) and assesses the urgency of the presenting problem. Entrants who want brief social services tend to fall into one of two very different categories: the stable family in need of brief, temporary service, and the extremely needy high-risk woman who wants money or goods without further involvement. In urgent situations, one of Family Place's three bilingual paraprofessional social workers provides immediate individual counseling and intervention to help the woman and her family deal with the immediate crisis, whether it be need for shelter that night, assistance in coping with a domestic crisis, child's illness, or a severe postpartum depression.

All entrants are given an orientation concerning the purposes and goals of Family Place. When a woman seems apparently uninterested or so overwhelmed by an emergency that she is unable to pay attention, this orientation will be brief. Nonetheless, from the beginning Family Place emphasizes the necessity for prenatal care and attention to the developmental requirements of children.

If the new participant is pregnant, referral for prenatal care is made immediately to one of the four prenatal clinics in the area. Every effort is made to ensure that the referral "takes": transportation money can be given if needed, and a veteran participant or staff member may accompany the woman to the clinic. Family Place also monitors the quality of participants' experience with prenatal care, helping new participants to be appropriately assertive.

Within a week of a woman or family's first visit to Family Place, the intake worker conducts a second, more in-depth interview. A case manager then assigns the participant to a case worker, who will work with the family to draw up and agree upon a service plan. Through both its successful and unsuccessful experiences, and through interviews with participants and former participants, Family Place has tried to learn how to deal tactfully and effectively with mismatches between agency and client goals and objectives. For the high-risk, uninvolved woman, limited service visits are used as a tool for outreach. Our goal is to help her use Family Place both as a means to getting essential services, such as prenatal care, in the community and as an ongoing source of support for herself and her children.



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Independence and interdependence

In the initial weeks of work with a participant, the caseworker typically must provide intensive and comprehensive family support services. As soon as a family's emergency is under a measure of control and the participant has had enough relief to enable her to pay attention, Family Place staff take steps to build both the participant's self-reliance and sense of belonging to a larger group. The process of transferring responsibilities to the participant herself and the larger group usually begins on the third or fourth visit to the center. A staff member who is key in the process of incorporating new members into the rest of the "family" is the Activities Coordinator, who organizes bimonthly field trips; family-like celebrations of holidays and birthdays; and "graduation" ceremonies for participants completing classes and courses.

Generally within a few weeks of her coming to Family Place, the participant and staff perceive positive changes in the way she feels and looks and in the way she relates to her children. The mother takes care to ensure that the environment is safe for her children and other toddlers. By observing her peers, she learns that a child can be disciplined without violence. Participants learn that in the very large "household" that is Family Place, they must take responsibility to avoid chaos. The shared laundry, kitchen, changing areas, nursery and playroom must be used properly and kept in order so that everyone can use them. Similarly, meals at Family Place

not only provide the major source of nutrition for some families, but also foster social life, mutual service, hygiene, knowledge about the dietary needs of children and adults, respect for cultural diversity in food preferences, and understanding and acceptance of the developmental need of babies to experience the messy process of learning to feed themselves. Family Place fosters family life skills in the context of daily living.

Support, skill building and education in groups

It is family-like interaction at the center that builds community and breaks down the isolation and mistrust that paralyze many immigrants. In addition, Family Place offers regular group programs to help participants increase their knowledge and become more self-reliant and better parents. Some groups are designed primarily to give participants a place to voice ideas and feelings, tell their stories, and give and receive emotional support. Other groups offer participants the opportunity to exchange information about the confusing and often frightening systems of a big city, or to collaborate with other community-based organizations. Some groups teach specific skills.

Participant support groups

The Wednesday Support Group discusses diverse topics, usually chosen by participants. Constantly recurring themes are love, loneliness, good and bad relationships, longing for family members left behind in the country of origin, and survival in an environment that is at best indifferent, at worst actively hostile. Some

of Family Place's more focused groups, such as a six-month series of discussions on self-esteem, have grown out of the Wednesday Group.

The Monday Support Group has focused for the past two years on domestic violence and alcoholism. Led by a staff social worker, the group offers battered women an opportunity to express their pain, anger, and feelings of powerlessness, and to learn about shelter resources, police protection, and legal rights. The sessions also explore the impact of domestic violence on infants and children. Because a large number of women had reported alcohol abuse as the triggering factor in domestic violence, an alcoholism counselor from a nearby mental health center has frequently facilitated the group.

Pregnancy education and preparation for childbirth

Proyecto Madres presents weekly classes in a five-session cycle for pregnant women on topics such as prenatal care, preparation for birth, breastfeeding and infant care. In 1989, 196 women attended these classes.

Six years ago the phone had just been hooked up in the Family Place's as yet unrenovated basement quarters when it rang with an urgent call from a nurse at Providence Hospital. A son had just been born to a young woman who spoke only Spanish and now, for no reason they could fathom, she was hysterical and obviously terrified. Could someone find out what was the matter? Joe Citro, Family Place's first staff member, gleaned from Sandra's tearful, incoherent gasps that she believed the hospital intended to take the baby away from her. (What in fact had been said was that the baby might have to stay in the hospital a few days longer than the mother). Joe quickly reassured her and then went over to the hospital.

Sandra had good reason to fear cruel and arbitrary power. Only a few months before she had watched helplessly as her husband was dragged away by the police of the Central American country where she was born. When she saw him next it was to identify his mutilated body.

Sandra was born in a small rural village, the youngest of three daughters. She showed exceptional ability in school and was awarded a scholarship to the country's best high school, located in the capital. There she met and fell in love with Pablo, who was a year ahead of her in school, and when he graduated they were married. Sandra was sixteen.

Both became very active in their local Catholic youth organization through Sandra's older sister, who was a nun. One day the group was to hold a rally for its members in the city square, and Sandra and Pablo set out to join it. As the bus pulled into the square, they realized that they had left their placards at home. Sandra volunteered to return for them. Pablo left on the bus, and as it pulled away,

A Natural Childbirth Exercise Class, taught by a certified volunteer teacher, graduates groups of six to seven pregnant women every six weeks. Participation in these classes has increased our participants' confidence and pleasure during childbirth.

Parent/child education and activities

In addition to weekly parenting education sessions that cover a wide range of topics, Family Place also offers classes and activities that focus on specific themes or issues.

Training in language development in babies and toddlers is offered in four-session cycles to groups of six to seven mothers with their babies and toddlers. We began this program in collaboration with specialists at the Scottish Rite Center for Early Childhood Language Disorders, in response to concern about the language delays frequently observed in Family Place children: We have observed a common pattern in which anxious mothers overprotect their infants and anticipate their toddler's every need, thus reducing verbal

Sandra saw the police rushing in from all directions to arrest the group members. She watched in terror as they grabbed Pablo and led him away. She never saw him alive again.

Sandra's mother, fearful for her daughter's life, immediately took her out of the country. Soon after arriving in the United States, Sandra found that she was pregnant. To support herself she took a seven-day-a-week job as a live-in domestic. Her job contract called for the cost of her meals to be deducted from her salary. Worried that she would not have enough money to pay for the baby's delivery, she ate one cheese sandwich and one glass of milk a day during her last four months of pregnancy. The birth of the baby, following just months after the death of her husband, returned joy to her life, joy that was shattered when she misunderstood the nurse speaking to her in English. It was in this crisis that Family Place began to help.

The lack of proper nutrition during the pregnancy had taken a toll on the newborn. The baby was hospitalized twice during his first month of life. Family Place staff worked around the clock getting care for the baby and accompanying the mother in her sorrow and confusion.

But by the time he was one, Jose was healthy and strong. Sandra became a warm, caring and knowledgeable mother. Eager to complete her education, she went to high school at night. A year later a young man named Francisco asked her to marry him. Right now Sandra and her family, including a brand new baby boy, live at a U.S. Army base in Germany where Francisco is stationed. Jose, who is six years old now, is the Family Place's oldest graduate.

Both of Anita's eyes were black, and there were bruises in a five-finger pattern on her neck and arms when she first appeared at Family Place in 1987. The friend who brought her had urged Anita to leave her drug- and alcohol-using husband. The beatings were occurring with ever-increasing frequency. But Anita felt trapped. Their two year old daughter, June, had cerebral palsy and Anita was pregnant. She had no source of support other than her husband. He was a pretty good father when he wasn't drunk or high, and besides, she both felt sorry for him and agreed with him when he blamed his drinking on her bad moods, his irregular employment, and his anxiety about their handicapped little girl. She hadn't begun prenatal care, although she was well aware of its importance. This was mostly because of the inertia of depression, but she also was ashamed of her bruises and wanted no questions asked.

Over the next months Anita and her social worker explored and tried several options. These included marriage counseling and referral of her husband to AA. Since he was mainly a weekend drinker, they tried having Anita and June spend weekends away with friends. Just having the sense that she wasn't at a standstill helped Anita. She conscientiously kept her medical prenatal care appointments. She attended

Family Place's prenatal education classes and, with June, participated in the weekly sessions for children with disabilities and their parents.

Anita's pregnancy was difficult. She was depressed and anxious about her marriage and apprehensive that the second baby might turn out to be damaged too. But she no longer felt overwhelmed. She was able to use the friendship and counsel that was offered her. She enrolled June in a therapeutic school that she learned about in the parents' group. Anita's second daughter was born healthy and she thrived. But the marriage went from bad to worse. Finally Anita separated from her husband after applying for a court order to protect her from his abuse. Family Place helped Anita secure good day care for her now six-month-old baby. She found a job and moved to her own apartment. In recent months she has provided advice, inspiration, and a temporary place of refuge to other Family Place participants who have experienced domestic violence. This is not the end of the story, of course. But Anita, while continuing to hope for her husband's recovery, is discovering her own strength and capacity for happiness. She has new confidence that she can provide a home for her children.

exchange between mother and child. The limited English-speaking skills of parents and other adults in the home raise another set of issues for the children. Mothers who have been trained through the language development program are in turn providing training for other groups of Family Place participants.

Sessions on nonviolent discipline, frequently conducted in collaboration with Rosemount Child Care Center's "A Good Beginning" program, offer parents an opportunity to talk about the tensions arising from difficult periods in the growth and development of their children, and the stresses of raising young children in poverty. Parents are offered non-abusive and non-violent alternatives to spanking, hitting, name-calling and other types of physical or verbal abuse.

Toy-making workshops use a manual prepared by the Avance Family Resource Center in San Antonio, Texas to offer parents and children creative, enjoyable and constructive times together making toys from cardboard boxes, scraps of clothing, "orphan" socks, sponges and other materials.

Health education

The Cooperative Extension Service of the University of the District of Columbia holds biweekly sessions at Family Place in Spanish on a variety of topics related to the transition from life in rural Central America to an urban environment. Topics include health and nutrition, personal and household hygiene, infectious diseases, caring for a sick child, household management, and stress reduction.

Alianza and Salud, Inc., two community organizations, offer biweekly workshops at Family Place on HIV infection and AIDS. Confidential referrals for HIV antibody testing are offered to participants considered at risk for infection.

Jobs and skills development

Several structured training sequences, including testing and certification, give Family Place participants the opportunity to acquire skills they need for more rewarding and stable employment. Because the structure of these programs, the classroom setting, and testing can be very stressful for participants, we use specific strategies to make sure that participants will experience success. These include a careful selection process for specific courses, adaptation of material and teaching methodologies, and incentives such as stipends and respite child care.

English as a Second Language (ESL) and literacy classes are offered. A Spanish language version of the American Red Cross's Babysitting Training Course was prepared by Family Place. Two staff members, who have been certified as trainers by the American Red Cross, are training and certifying groups of eight women in cycles of four four-hour sessions.

Specialized individual services

Family Place staff provide one-to-one guidance sessions to an average of 15 families per month. Offered to parents at risk of abusing or neglecting their children, the sessions are individualized to meet the needs of each parent. The Bebes Especiales Project offers

intensive, individualized services to families with infants with disabilities. Supported by the National March of Dimes and the Handicapped Infant Intervention Project of D.C. General Hospital, services include hospital and home visits, translation and interpretation, and referral and follow-up.

Family Place staff also assist families individually around jobs and child care, helping participants clarify their goals, assisting with job applications, arranging education and training opportunities, making day care referrals, and facilitating arrangements to share living space, work, and child care responsibilities.

Participants helping participants

In addition to the informal support that Family Place participants provide each other daily, current and former participants also assist each other in more structured ways—exemplifying the interdependence that is a Family Place goal.

Family Place participants provide emergency short-term shelter to scores of families each year. This compassionate response from families who themselves lack many resources is an amazing demonstration of the community that is being built through Family Place. To assist these generous families, the center provides food, transportation tokens, and, if needed, small sums of money.

The Respite Child Care Program, started in 1989, cares for five to eight children each day while their parents are attending classes. Care is provided by a child care assistant on the Family Place staff and by volunteer Family Place mothers who have taken an eight hour training course.

The First Friends Program began at Family Place in 1983, to assist women who might otherwise have no one to take a special and consistent interest in their pregnancy and new baby. Volunteer mothers—most of them active or former participants in Family Place—maintain regular contact with first-time or high-risk pregnant women, providing encouragement, advice and help. A First Friends Coordinator provides regular training sessions for individuals interested in becoming a First Friend, and social services staff provide back-up support.

Since 1986, an elected Participants' Council has organized small fundraising efforts and special activities such as the Family Place Annual Picnic and the Mother's Day celebration. The President of the Participants' Council represents the community of participants on Family Place's Board of Directors.

The Family Place support system

To enable Family Place staff to provide comprehensive and, initially, intensive family support services to an average of 450 families per year, we have sought and obtained the support of foundations, churches, individuals, corporations and government. Volunteers have been essential and continue to sustain Family Place. Without our own "support system" we would not be able to nurture and encourage our families to become independent, and to help their children develop well.



In the first years of Family Place, our scarce resources and energies have been directed primarily toward meeting the most urgent needs of our families: adequate prenatal and pediatric care, prompt intervention during crises, food, clothing, shelter, and parental guidance to prevent child abuse and neglect. A recently-awarded four-year grant from the W.K. Kellogg Foundation will enable us to strengthen our services, especially those directed to child health and development; improve our case management system; and better evaluate our program.

Family Place's experience in serving Central American immigrant and refugee families has taught us that our center must respond to the expressed needs, desires, wants and dreams of our parents. We should continue to develop and implement our programs "from the bottom up" within our local community. We should always seek and build upon the strengths of individuals and families. As committed and caring staff, we must continue to create an atmosphere of respect and affirmation for our parents and children, nurturing parents so that they can nurture their children. The future of our community, and of our country, is at stake.

Ethnic Differences in the Transition to Parenthood

by

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Although the transition to parenthood is a time of stress, researchers have documented that social support can relieve stress and promote adaptive coping during this critical period (e.g., Cowan & Cowan, 1987; Crnic, et al., 1984; O'Hara, 1986). To date, however, most of the studies on the relationship between social support and stress during the transition to parenthood have primarily focused on white, middle class women. A new investigation at Northwestern University Medical School is looking at black, Hispanic, and white women from a wide range of socioeconomic classes to compare the process of adjustment to parenthood as it occurs in the often non-traditional families of three different ethnic groups.

The current study is a follow-up to an investigation funded by the National Institute of Child Health and Human Development that studied the relationship between prenatal lifestyles and low birthweight outcome in 500 pregnant women receiving care at Prentice Women's Hospital in Chicago, Illinois. The sample included approximately 200 black women, 50 women of Mexican origin, 50 women of Puerto Rican origin, and 200 white women.

After completing the prenatal study, which had included interviews during routine obstetrical visits in the second and third trimesters, the women were asked to participate in a follow-up investigation of the postpartum period. The 320 women who agreed later completed at least the first of two additional interviews—the first in the hospital, generally within 48 hours after delivery, and the second during their routine checkup, generally at about six weeks postpartum. During these hour-long, face-to-face interviews, they were asked questions about depression, self-esteem, social support, marital satisfaction, and stress. The measures used included:

- The Center for Epidemiologic Studies—Depression Scale (CES-D; Radloff, 1977): assessing the current level of major dimensions of depressive symptomatology

- The Rosenberg Self-Esteem Scale (Rosenberg, 1965; Robinson & Shaver, 1973): measuring favorable/unfavorable attitudes toward oneself

- The Psychiatric Epidemiology Research Interview Life Events Scale (PERI; Dohrenwend, Krasnoff, Askenasy, & Dohrenwend, 1982): providing information about stressful life events recently encountered by a mother and those close to her

- The Social Network List (SNL; Samin & Michaels, 1987): asking the mother to name individuals currently important to her and to comment on the ways these people are supportive

- The Maternal Social Support Index (MSSI; Pascoe, Loda, Jeffries, & Earp, 1981): assessing aspects of a mother's social support network that may be related to her caregiving capacity—e.g., availability of help with daily household tasks and child care, the presence of a communicative male and other adults, community involvement

- The Short Marital Adjustment Test (Locke & Wallace, 1959): measuring the quality of, and the mother's satisfaction with, her relationship with her primary partner

- The Parenting Stress Index (PSI; Abidin, 1983): identifying those stressors which are most commonly associated with dysfunctional parenting.

Together the four interviews—two prenatal and two postpartum—were designed to provide comprehensive assessments of stability and change in psychological functioning and psychosocial variables from pregnancy to the early weeks of the transition to parenthood.

The study design is based on the assumption that although the transition to parenthood is generally a time of stress, specific aspects of an individual woman's life can either intensify or relieve the amount of stress experienced and its harmful effects. At this time, data collection for all four interviews has been completed. As data from the interviews area analyzed, the following hypotheses, among others, will be examined.

- Does personal distress in the mother, either during pregnancy and/or postpartum, affect her adjustment?

- Does the mother's satisfaction with her relationship to her partner affect her adjustment?

- Does the mother's perception of the adequacy of her social support affect her adjustment?

- Does ethnicity interact with each of the other three variables i.e., maternal distress, partner relationship, and social support?

- In other words, will the level of maternal distress affect mothers' adjustment differentially depending upon ethnic group? Similarly, will partner relationships and perceived social support differentially affect maternal adjustment depending upon ethnic group?

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National Center Notes

by Eleanor S. Szanton



In the September, 1989 issue of *Zero to Three*, we announced receipt of a five-year Maternal and Child Health Improvement Project Demonstration Grant (MCJ - 115041). Entitled "Promoting Success in Zero to Three Services," the grant called for the selection

of five communities or programs utilizing community-wide prevention strategies in working with those infants and toddlers and their families needing extra support. The program features required for selection were primarily the following:

- Universal access, without regard to some "preliminary diagnosis" or categorization;
- Mainstreamed, non-categorical services for young children with special needs and others alike;
- Linkages across a range of levels of care and service systems, so that these infants and toddlers and their families have easy access to various kinds of preventive health, screening, diagnosis and treatment services, beginning with prenatal care and extending to preschool;
- Professional development opportunities, including continuing education, networking, and collegial support for staff;
- State support and encouragement of these communities or projects as possible models for replication elsewhere in the state.

The National Center called for nominations of communities and programs over the summer and early autumn. We received scores of nominations and then

engaged in a period of assessment of written materials and personal conversations with leaders of a number of the most promising projects, as well as consultation with members of our Advisory Committee for the project. The five communities chosen to collaborate with NCCIP in this demonstration are:

- Project Echo, Fremont County, Colorado;
- Family Focus Lawndale, Chicago, Illinois;
- Kids Place, Scottsburg, Indiana;
- Warwick Interagency Review Council, Warwick, Rhode Island; and
- the Snohomish County Interagency Council, Snohomish County, Washington.

These programs were chosen not only for their high quality but also because they represent diversity of regions, of demographics and of sponsorship. We look forward to working with these communities as we collaborate in mutual discovery, analysis and exchange of program features which have been most effective.

As our collaboration continues, we hope to be especially alert to community approaches that involve and strengthen all the people who have an impact on the development of infants and toddlers. This means mobilizing the strengths, and addressing the needs, of fathers and boyfriends as well as mothers, of grandparents and other family members, and of natural helpers in the community. It means systematic outreach, and ways of operating that invite the participation of people who may feel excluded from traditional community services. It means strengthening the ongoing coping of families and informal support networks rather than creating "top-down" organizations. It means looking beyond "units of service delivered" to see child and family outcomes achieved.

The National Center Fellowship Program: Nurturing New Leaders

by

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and

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Powerful financial and career pressures keep many talented human services professionals away from work with infants, toddlers and their families. And these same pressures continue, unrelenting, pulling professionals who enter the field of infancy away from their avowed goals. It is a loss to young children and families whenever a student of infancy lacks encouragement and support, whenever a front-line practitioner leaves the field in discouragement, and whenever a professional full of talent and ideas is underused or isolated.

The Fellowship Program of the National Center for Clinical Infant Programs, established in 1981, represents an effort to encourage a small number of outstanding advanced trainees from a range of disciplines to see themselves as leaders in the infancy field, affirming their resolve to remain in the field and to contribute to it. It reflects NCCIP's commitment to improving the training of researchers and practitioners who work with infants, toddlers and their families that has been a goal of the National Center since its inception in 1977. Training is viewed as a lifelong process, involving intellectual and emotional support from colleagues as well as more formal educational experiences. Continuing learning also comes from reflection in supervision, and from opportunities to refine ideas for presentation or publication.

In the fall of 1988, an independent investigator, Ray Collins, and his firm, Collins Management Consulting, Inc. (CMC) undertook an evaluation of the Fellowship Program as it operated from 1981-1988. The findings of CMC's study, summarized in this article, illuminate many of the challenges involved in trying to increase the supply of competent, experienced professionals available to very young children and their families. Study findings also suggest ways in which a relatively modest undertaking can have a widening, ongoing impact—a reminder of the wisdom of investing in the early years of professionals, as well as of children and families.

Overview of the NCCIP Fellowship Program

The Fellowship Program is designed "to encourage a new generation of leaders in the field of infant health, mental health and development" by providing enrichment opportunities to advanced trainees who are committed to teaching, research, and the creation of effective models of clinical services for infants and their family. Nominated by sponsors in their training

institutions and selected by NCCIP's Fellowship Committee, Fellows participate for one or two years in a program which includes:

- An annual Seminar Week featuring presentations by Fellows and an introduction to the research and clinical activities of the host training center;
- Participation in NCCIP National Training Institutes and invitational scientific meetings.
- A modest cash stipend, to be used at the discretion of the Fellow, generally applied to visits to additional training centers and purchase of books, computer time, or other research supports.

Highlights of the CMC study findings

The CMC Study of the first seven years of the NCCIP Fellowship Program used mail questionnaires to all Fellows and sponsors and telephone interviews with a random sample of 25 Fellows. The study addressed six principal questions.

1. What are the characteristics of the NCCIP Fellows who participated in its program through its first seven years?

The typical National Center Fellow, if there were such a phenomenon, would be a white, 37-year-old female pediatrician, married, with one child, living in Massachusetts. Seventy percent of the Fellows have been female. Approximately half the Fellows have come from Massachusetts, Connecticut and New York, although Fellows have also come from 16 other states and Canada. Pediatrics and psychology have been the disciplines of the majority of Fellows. Child psychiatrists and nurses have constituted the next largest groups, with smaller numbers of Fellows coming from social work, child development, special education and other disciplines.

2. To what extent have Fellows remained in the infancy field?

Fellows tend to engage in teaching, research and clinical services with a heavy multidisciplinary emphasis. Twenty-five percent of the Fellows reported that they worked exclusively in the infancy field; five percent were not at all involved in infancy. Several Fellows mentioned that despite a preference for work with very young children they have been forced by economic pressures to engage in professional activities not related to infancy. Others reported that support for a focus on the infant/toddler period was lacking in their professional institution.

Eighty percent of Fellows reported that the National Center Fellowship experience had been important in either keeping infancy the dominant theme in their career or keeping them meaningfully involved in the infancy field for at least a portion of their time. Access to a network of NCCIP Board members and other Fellows was esteemed by all Fellows but may prove particularly important to those Fellows who see themselves as isolated infancy pioneers in institutional "frontier territory."

3. What impact did the Fellowship Program have on participants' professional development?

Eighty percent of both Fellows and sponsors who responded to the CMC study reported that the Fellowship Program has had either a "decisive" or "substantial" impact on Fellows' identity as an infant specialist. Fellows and sponsors were asked about the program's impact on Fellows' identity as an infant specialist; self-image as a future leader; functioning as a cross-disciplinary thinker; development as an infant researcher; access to leaders in the infancy field; involvement in public policy; and placement in their current job.

Fellows began to see themselves as future leaders in an interdisciplinary field. A number of Fellows reported current involvement in cross-disciplinary research projects as well as teaching, clinical or supervisory roles that bridged several disciplines. While only a quarter of the Fellows reported that the program had had a decisive or substantial impact on their own involvement in public policy, many credited the experience with increasing their awareness of public policy issues related to infants, toddlers and their families. They were impressed by the activities and policy impact of individual NCCIP Board members as well as the organization as a whole.

4. To what extent have Fellows contributed to the field and demonstrated leadership or the potential for leadership?

Their sponsors tended to rank Fellows highly as leaders or potential leaders in teaching, multidisciplinary activities, clinical services and research. Fellows saw each other as leaders, with a few Fellows regarded by their colleagues as "superstars." Many Fellows indicated that their NCCIP experience made them aware of their own capacity to make a leading contribution to the infancy field. Fellows have demonstrated leadership by collaborating with other Fellows and with their sponsors on joint research projects, in writing articles and books, in developing assessment tools, in representing NCCIP at infancy meetings, and in other leadership activities in which they were contributing state of the art knowledge and skills.

5. What features of the Fellowship Program make the greatest contribution?

For most of the Fellows, the seminar week (see sidebar) was the intellectual and emotional highlight of their experience. However, the ongoing contact with NCCIP Board members, other Fellows and National Center staff was seen as making the greatest overall contribution to their developing sense of themselves as infant specialists and future leaders.

The Seminar Week experience

The highlight of the Fellowship year has been seminar week, a five day retreat in which Fellows present their work in progress in an environment that is conducive to learning and exchange of ideas among a group from a variety of disciplines and perspectives. Seminar week has been hosted in five different sites over the past seven years. Each retreat has had its own characteristic tone or theme, varying with the setting, the nature of the host center, the composition of the fellowship class, and the themes of topics presented; yet each has been strikingly successful and deemed the hallmark of the program.

How is seminar week planned?

The host center, chosen by the Fellowship Committee, usually includes a sponsor of one of the Fellows in the program. The Fellowship program coordinator supplies the host center with the agenda and evaluations from previous years' seminar weeks, and with summaries supplied by each Fellow of his or her interests, plans for the year, and topic. Each mentor, or sponsor, is asked to work closely with

"At least half of the value of seminar week for me were the shared experiences with Fellows, faculty and guest speakers that occurred before, after or between scheduled sessions."

Fellows in planning the seminar week presentation. Fellows are asked to submit an abstract and audiovisual needs two months before seminar week. Using this information, the host center forms a committee to plan the agenda. Topics are grouped and discussants are invited to comment. There is a discussant for each Fellow. The schedule also includes faculty presentations, a site visit and leisure time, both group and individual.

What does the agenda look like?

The week begins with a social event in which Fellows and members of the host center staff and their invited discussants have an opportunity to meet. It is desirable but not essential for Fellows and discussants to talk in advance. Fellows' presentations are for 30 minutes, followed by a 15 minute response by a person with expertise in a closely related area, and 15 minutes for general discussion. Thus each Fellow is allotted one hour. Topics are clustered by the host center, so that themes are developed where possible. For example, three presentations may relate to infant-caregiver relationships; or two presentations may use the Strange Situation paradigm.

The host center may invite faculty to present their own work, and there may be a field visit. We have found that it is important to permit leisure time. To the extent possible evenings are free, and at least one opportunity is planned for a group outing. At

Yale, it was a dinner at Mory's and another at the home of several faculty members; in Colorado, there was a day of skiing and a party at the home of a graduate fellow; in San Francisco, there was a barbeque and a trip to Tiburon; a whale watch was the highlight of seminar week at Cape Cod.

On the last evening Fellows have developed some way of expressing appreciation to the faculty, generally with small gifts or songs, and there has been a faculty response. This has contributed to the cohesion of the group and the spirit of the week. A wrap-up session on the final morning ties the week together.

"I greatly appreciated the opportunity to interact with faculty during leisure activities and in-between planned activities. The informality of the setting made it much easier to approach faculty members to discuss both professional and personal issues."

What do the discussants do?

Having reviewed the abstract, the discussant reacts to the presentation, generally commenting on the nature of the work, and placing it in a broader context. Discussants are instructed that the seminar experience is intended to be supportive and encouraging, although constructive criticism is appropriate. Discussants also facilitate the questions and comments from other Fellows and faculty who may be present.

How has the seminar been evaluated?

Each year, Fellows are asked to identify what they gained from preparing for the seminar, from attending the seminar, and from the Fellowship experience in general. Additionally, sponsors are asked to prepare an evaluative statement about the experience. Since sponsors do not attend seminar week, their summary is based on what they are told by Fellows.

How can the seminar week experience be adapted by other programs?

For programs that seek to establish a network, the kinds of experiences provided in seminar week seem to offer a relatively economical way to develop collegial bonds. The ingredients include selection of scholarly and curious Fellows, a faculty with expertise and interest in mentoring, time for exchange of ideas about areas of common interest, both formally and informally in leisure activity, an atmosphere which is challenging yet not threatening, a mix of serious work and an opportunity for fun, all within the span of approximately four days. These comprise an investment that yields long term dividends in human relationships and commitment to the field.

6. What changes, if any, should be made in the Fellowship Program?

Respondents in the CMC study saw a need for expansion of the program but felt that spreading existing resources more thinly, by limiting participation to one year only, would dilute the impact of the program. Respondents varied in their thinking about the relative emphasis that should be given to research and clinical services within Fellowship activities; a number of Fellows saw the mix of clinical and research perspectives as valuable in complementing the backgrounds they brought to the program. Suggestions to broaden the Fellowship program to include nominations from clinical and community action programs, as well as from academic institutions, have already been implemented, with the hope that this approach will increase geographic, cultural and ethnic diversity among participants.

Implications for leadership development

The National Center's Fellowship Program seems to be an undertaking whose whole is dramatically greater than the sum of its parts. Each single aspect of the program is modest—the stipend, the time spent by participants specifically on Fellowship activities, the time and resources spent on administration, the contact with sponsors and NCCIP Board. Nevertheless, the cumulative impact of the one or two-year Fellowship experience does seem to consolidate Fellows' identities as infant specialists. Equally important, continuing connections with the entire group of graduate and new Fellows, and with NCCIP Board and staff, seem to confirm Fellows' strivings toward leadership and to offer opportunities for collaborative contributions to the field.

Other professional organizations, training institutions, clinical settings, and even geographic regions or governmental jurisdictions could consider adopting features of NCCIP's Fellowship Program in order to identify and nurture leadership in the infancy field. The elements that seem critical to success include:

- A commitment by existing infancy leadership within the organization, institution or community to devote the time required to select fellows, plan meaningful activities, and be available for informal "networking."
- Resources to support some version of Seminar Week, where Fellows have an opportunity to experience themselves and others as contributing clinicians and researchers and to forge personal links with each other and mentors;
- A blending of perspectives, across disciplines and across fields of professional activity (i.e., research, clinical practice, teaching, public policy), that reflects the field of infancy at its most comprehensive and offers a variety of opportunities for continued learning and for personal contribution;

- Ongoing institutional and personal connections to reinforce fellows' identities as infant specialists, particularly for Fellows facing geographic or professional isolation.

- Planned opportunities for graduate Fellows to participate as contributors, mentors, and leaders within the sponsoring body.

No one small cadre of leaders in the field of work with infants, toddlers and their families can possibly fill the demand that currently exists and will continue to grow. Nor can leadership—any more than the development of an infant—be nurtured by a large-scale, impersonal effort. Nevertheless, small programs, characterized by warmth, mutual respect, and a shared commitment, offer great promise as a way to make the field of infancy an inviting place for talented people to work.

Publications

Born and Raised in East Urban: A Community Study of Informal and Unregulated Child Care (1990)—Caroline Zinsser (New York: Center for Public Advocacy Research, Inc.) Available for \$5.00 from the author, 45 East 62nd Street, New York, NY 10021.

This study of informal and unregulated child care in a white, ethnic working class neighborhood in a northeastern city is based on interviews with community members. In the past, parents in this community have relied for child care on their families and well known, trusted neighbors. They have avoided care by "outsiders," including professional caregivers in day care centers. With the number of relatives available for child care shrinking and working class households increasingly dependent on the earnings of both parents, the supply of informal arrangements is no longer adequate to the demand.

The report describes in some detail the world of unregulated "babysitters" in this community. These women choose their work as an extension of their traditional roles of mother and housekeeper and are guided by local community values. By charging according to what parents can pay, they in effect subsidize their services, but they operate "off the books" to avoid paying taxes on their low wages. They can provide "affectionate, safe, reliable care," but in the absence of formal training, their child care is modeled on the folkways of their community rather than on professional standards of child development.

The study concludes that in a changed economy, parents need outside, government-sponsored assistance in caring for their children. The study also emphasizes that "any national policy must respect the cultural settings in which people make choices about their children. Those concerned with children's care need to recognize the strengths of what is already in place and to support quality child care no matter what its auspices, whether by relatives, by trusted neighbors, by regulated

family day care providers, or by licensed day care centers."

The Cultural Context of Infancy, Volume 1: Biology, Culture, and Infant Development (1989)—J. Kevin Nugent, Barry M. Lester, and T. Berry Brazelton, editors (Ablex Publishing Corporation, 355 Chestnut Street, Norwood, NJ 07648) \$59.50 for institutions, \$35.00 for individuals.

This volume begins a new series of publications designed to describe the developmental processes of infancy over a wide range of cultural and social environments. The editors describe the goals of the series as: 1) to assemble reports of original empirical research on infancy from countries around the world; 2) to present material from a variety of disciplinary perspectives; 3) to document the use of the Brazelton Neonatal Behavioral Assessment Scale as a research tool in different cultural settings; and 4) to examine the relationship between biology, culture and infant development by documenting different neonatal environments and child care practices in different cultures.

This volume includes 13 chapters that document biosocial influences on newborn behavior, mother-infant interaction in the first year of life, and cross-cultural comparisons in countries from Malaysia to Zaire. Chapters on teenage childbearing in traditional Puerto Rican culture, a normative study of black infants, infant behavior and childbearing among the Hmong in America, and behavioral styles of Navajo infants address the interweaving of biology, culture, and infant development within our own increasingly diverse society. In his afterword, T. Berry Brazelton notes "that all of the studies focus on the newborn baby's behavior as an outcome of a combination of the genetic endowment and the intrauterine influences that have already shaped it at birth Repeated assessments over the period of the neonatal adjustment will present us with a window into the coping patterns of neonates in each culture. As we link environmental observations of parent-infant interaction to those neonatal assessments, we can begin to get a better idea of the interaction of nature and nurture."

Anti-Bias Curriculum: Tools for Empowering Young Children (1989)—Louise Derman-Sparks and the A.B.C. Task Force (National Association for the Education of Young Children, 1834 Connecticut Avenue, N.W., Washington, D.C. 20009-5786) \$7.00.

This book represents the work of a task force of early childhood educators who were dissatisfied with current curricula (especially "tourist" multicultural curricula or "colorblind" approaches) for helping young children learn about human diversity in color, language, gender, and physical ability. Convinced that children are aware very young that "differences are connected with privilege and power," the group worked together for two years to conceptualize and implement the anti-bias curriculum presented in this publication.

The philosophy underlying the curriculum is that differences are good; oppressive ideas and behaviors are not. Teachers and children are asked to confront troublesome issues rather than covering them up. Curriculum goals are "to enable every child: to construct a knowledgeable, confident self-identity; to develop comfortable, empathetic, and just interaction with diversity; and to develop critical thinking and the skills for standing up for oneself and others in the face of injustice."

The book addresses a range of issues including creating an anti-bias environment; learning about racial and cultural differences and similarities, disabilities and gender identity; learning to resist stereotyping and discriminatory behavior; and working with parents, among others. A chapter on working with two-year-olds offers guidelines for child-teacher interactions as children of this age become aware of gender and skin color and may show signs of discomfort with physical differences. Suggestions are also given for integrating anti-bias issues into parent discussions about the development of two-year-olds.

Black Families in Therapy: A Multisystems Approach (1989)—Nancy Boyd-Franklin (The Guilford Press, 72 Spring Street, New York, NY 10012) \$27.50.

"It is important," notes Nancy Boyd-Franklin, "that any program that trains therapists to work with families include formal instruction on cultural components . . . Therapists should be encouraged to use this cultural material not to develop rigid stereotypes but to develop hypotheses and questions that they can test out with each new family. Only then can they truly allow Black people to 'teach' them about their families."

This volume addresses aspects of the Black experience such as extended family systems, informal adoption, cultural and political values, and religious or spiritual orientation. The author also explores the distinct issues faced by different socioeconomic groups among Black families, including poor families, two-parent and single-parent families, middle-class families, and upper-middle-class families. A "multisystems" approach to treatment is presented, which provides a framework for intervention with and through the individual, family, extended family, church, community and social services.

Although the volume does not present discussion or case material that deals specifically with infant/parent treatment, many of the issues that are described as bringing Black families into therapy have their roots in the parent/infant relationship. These include relationships between and among an adolescent mother, her infant, and the grandmother; ambiguities surrounding informal adoptions within an extended family; skin color issues; and "toxic" secrets that may have to do with parentage, especially fatherhood.

Ms. Boyd-Franklin suggests that her book can serve as an introduction to or summary of clinical issues in therapy with Black families. She also emphasizes the importance of supervision, collegial support, commun-

ity involvement and exploration of one's own cultural heritage as training experiences.

How Nations Serve Young Children: Profiles of Child Care and Education in 14 Countries (1989)—Patricia P. Olmsted and David P. Weikart, editors (High/Scope Press, 600 N. River Street, Ypsilanti, MI 48198) \$29.00.

"IEA" is the acronym of the International Association for the evaluation of Educational Achievement, a nongovernmental, nonprofit organization of research institutions in 45 countries. The IEA Preprimary Project is an ongoing international study investigating "the nature, quality, and effects of the experiences of children prior to formal schooling." This volume contains national profiles of early childhood care and education prepared by research teams in 14 countries: Belgium (French-speaking), the Federal Republic of Germany, Finland, Hong Kong, Hungary, Italy, Kenya, Nigeria, the People's Republic of China, the Philippines, Portugal, Spain, Thailand, and the United States. Although the project is studying children three and one-half to four and one-half years old, many of the national profiles in this volume address issues relating to children under three and their families.

The profiles reveal a range of national child care policies, many of which are undergoing reevaluation and change. In Finland, for example, "the 1980s witnessed a brisk discussion concerning child care arrangements. The discussion has shown that no general solution to the problems of child care exists. The government maintains that alternative child care systems should be available for families, so that each child's and family's particular circumstances might be accommodated. For the care of infants, family policy allowing parents to care for the child at home seems to be a solution. In the case of toddlers, the idea that the parents should be able to choose home care as an alternative to center or family day care has been stressed." The Nigerian profile notes that "government policy promoting infant and child welfare is almost nonexistent . . . The loss of traditional child care resources has spurred a rapid growth in urban day care centers set up to meet the needs of employed mothers . . . by nurses, teachers, secretaries, or any interested persons. It is felt that any mother is qualified to set up care services for children . . ." In her afterword, Lillian Katz notes that deficits in service availability, in agency coordination and in personnel quality seem to be recurring themes across countries. She also discusses the challenges that will arise in interpreting the cross-national data being collected by the IEA study.

A Welcome for Every Child: How France Achieves Quality in Child Care—Practical Ideas for the United States (1989)—Gail Richardson and Elisabeth Marx (The French-American Foundation, 41 East 72nd Street, New York, NY 10021) \$10.00.

This report is the result of a two-year project of the French-American Foundation in which 14 child care experts from the United States examined aspects of France's preschool and child care system.

Paid and job-protected maternity leave is seen in France as part of society's broad obligation to children and parents and is used almost universally. Financed by a payroll tax levied on all employers, the French law guarantees each woman 16 weeks paid leave for childbirth or 10 weeks paid leave for adoption. At the end of her leave, a woman returns to her former job in its identical form including all former benefits. Extended unpaid leave for up to two years is available to either parent but is used infrequently.

In France, staff training and experience are considered the foundation of quality in child care. In infant-toddler day care centers directors and assistant directors are pediatric nurses with special training in public health, child development, and program administration. Among a director's most important responsibilities are the supervision and training of less skilled staff. "Educators" have the equivalent of two years of college followed by a two-year professional degree in early childhood education and child development. In centers, educators are responsible for toddlers; in family day care networks they direct children's group activities. When entering preschool teacher-training programs, French graduate students agree to spend five years in the field after completing their degrees, in exchange for free education and modest stipends for living expenses. Salaries for child care professionals are comparable to those of other professionals with equivalent levels of training; turnover rates are low.

About 27% of all French infants and toddlers are served by centers, family day care networks, and independent licensed family day care providers; another 3% are cared for by unlicensed home-based caregivers. Parents pay for child care on a sliding scale based primarily on income. The report notes that in France "public policy respects parents' preferences for different types of out-of-home care by seeking to improve all types. Public financing is budgeted at the amount needed to bridge the gap between what parents can afford and what good programs cost."

Promoting Mental Health in Early Child Care Settings: Proceedings of the Second Annual UCLA National Conference on Preventive Psychiatry (1989)—Stephen E. Goldston, editor (UCLA Preventive Psychiatry Center). Available free of charge from the National Maternal and Child Health Clearinghouse, 38th and R Streets, N.W., Washington, D.C. 20057.

This volume includes twelve papers presented at a 1988 national conference organized by the UCLA Preventive Psychiatry Center in collaboration with the federal Office of Maternal and Child Health, which also supported publication of conference proceedings. Contributors are Carolyn Baum, Alison Clarke-Stewart, Stephen Goldston, Edmund Gordon, Christoph Heinicke, Carollee Howes, J. Ronald Lally, Alicia Lieberman, Douglas Powell, Sally Provence, June Solnit Sale, Sandra Wood Scarr, George Spivack and Yolanda Torres. Papers address mental and emotional factors relevant to the work of child care providers, "cross-

cutting" issues in child care, and retrospective and prospective analyses. The volume also includes edited highlights of the discussion period that followed each presentation.

A number of the papers endeavor to explore in some depth the implications of changing expectations of parents and caregivers, as well as the experiences of young children in alternate care. Carolyn Baum and Christoph Heinicke use a case vignette from a home visiting program to illustrate one family's resolution of conflicts related to the integration of work and family life after the birth of their first child. They identify as factors involved in the process of conflict resolution the mother's diminishing emotional closeness to her daughter; the availability of stable child care; the mother's general ability to resolve internal and external conflicts; and the support she experienced from both her husband and extended family. In discussing changing parent-caregiver relationships, Douglas Powell emphasizes dramatic changes in the structure and function of families; differing images among child care providers of appropriate ways parents should be involved with programs (as customers, learners, "program boosters," or decision makers); and matters of professional status, where efforts to achieve professional "freedom from client control" may jeopardize collaborative relationships with parents and effectiveness as a family support system.

Caring for Our Future: The Content of Prenatal Care (1989)—A report of the Public Health Service Expert Panel on the Content of Prenatal Care (Washington, D.C.: Public Health Service, Department of Health and Human Services) Available free of charge from the National Maternal and Child Health Clearinghouse, 38th and R Streets, N.W., Washington, D.C. 20057.

While a number of recent reports have cited prenatal care as the major factor in the prevention of infant mortality and morbidity, *Caring for Our Future: The Content of Prenatal Care* examines in detail the components of prenatal care and the timing and frequency of their delivery. The report represents three years of effort by an expert panel chaired by Mortimer Rosen, M.D. and initiated by the Department of Health and Human Services Low Birth Weight Prevention Work Group, chaired by Duane Alexander, M.D., Director of the National Institute of Child Health and Human Development and Vince Hutchins, M.D., Deputy Director, Bureau of Maternal and Child Health and Resources Development. Background papers that provide the basis for the Panel's analysis and recommendations will be published separately.

The report notes that in the past, prenatal care focused on the prevention of eclampsia and other maternal correlations of toxemia. In recent years, prenatal care has been more concerned with the identification and management of high-risk conditions for the fetus and newborn. A broader, contemporary view of prenatal care, according to the Panel, sees pregnancy as an opportunity to promote the health and

well-being of the family. In addition to assuring the health of the pregnant woman and the birth of a healthy infant, the objectives of prenatal care include the promotion of family development and positive parent-infant interaction, the reduction of unintended pregnancies, and the identification for treatment of behavior disorders leading to child neglect and family violence.

The report identifies three basic components of prenatal care: 1) early and continuing risk assessment; 2) health promotion; and 3) medical and psychosocial interventions and followup. Preconception care is seen as an integral part of prenatal care. The report recommends that the specific content and timing of prenatal visits, contacts, and education should vary depending on the risk status of the pregnant woman and her fetus.

For healthy women at no apparent risk during pregnancy, the report recommends fewer visits than are included in the suggested core visit schedule currently in use. However, greater emphasis is given to care in the preconception period and early pregnancy, and to enrichment of content. When medical or psychosocial risk is uncovered, the Panel recommends specialized services provided or coordinated by the woman's primary prenatal care provider. Core resources, which should be available for all women at psychosocial risk, include the ability to facilitate assessment of the family and the home environment, continued assessment of evolving psychosocial needs, coordination of treatment services, and supervision of the effects of the services offered to the patient.

Prevention of Mental Disorders, Alcohol and Other Drug Use in Children and Adolescents (OSAP Prevention Monograph - 2) (1989)—David Shaffer, Irving Philips and Norabert B. Enzer, editors (Office for Substance Abuse Prevention, U.S. Department of Health and Human Services). Available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, free of charge.

This volume represents the culmination of "Project Prevention: An Intervention Initiative," an interdisciplinary project developed by the American Academy of Child and Adolescent Psychiatry and supported by the Pew Charitable Trusts, the Ittleson Foundation, and the van Ameringen Foundation, Inc. Experts in the field were commissioned to review selected areas of research concerning known risk factors for children, such as psychiatric disorder in parents and chronic illness in childhood. Other chapters discuss theoretical and conceptual problems related to preventive interventions and to public policy. Contributors include Kathleen Bacon, William Eaton, Leon Eisenberg, Barbara Fiese, Ann Garland, Rosa Hagin, Karol Kumpfer, Raymond Lorion, Kathi Nader, Terence Nolan, D.R. Offord, Irving Philips, Barry Pless, Richard Price, Robert Pynoos, Michael Rutter, Arnold Sameroff, David Shaffer, Archie Silver, and Morton Silverman.

As Leon Eisenberg of Harvard Medical School notes in his essay, "Public Policy: Risk Factor or Remedy?", "Policies designed to promote health and to prevent disease should be evaluated by the health outcomes they yield in the population. Advocating prevention on the promise of cost containment is a dangerous strategy. Prevention is sometimes less costly for the government budget than cure; more often, effective prevention offers better health at additional public cost Few quick fixes lie in store for the psychiatric disorders of children."